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Issue Date: 01 July 2004

Case No. 2001-BLA-00067

In the Matter of

ROY JOHNSON, JR.,

Claimant,

v.

BIG ELK CREEK COAL CO., INC.,

Employer,

and

OLD REPUBLIC INSURANCE CO.,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Respondent.

DECISION AND ORDER ON REMAND

The undersigned issued a Decision and Order denying benefits in the above-captioned matter on July 23, 2002. Following a timely appeal by the Claimant to the Benefits Review Board ("BRB"), the BRB, by order dated August 29, 2003, remanded the case to me for reevaluation of certain medical evidence. Specifically, the BRB held that although I had properly discredited Dr. Glen Baker's finding of "clinical pneumoconiosis," I improperly found that Dr. Baker's opinion did not constitute "legal pneumoconiosis." The BRB vacated my findings stating that I ". . . did not provide a basis for finding the opinions of [Drs. Lockey, Branscomb and Fino] better reasoned than Dr. Baker's contrary opinion nor is it apparent from the face of the doctors' reports. The BRB instructed that,

on remand, I must reconsider the relevant medical opinions of record and provide a valid basis for all my findings and to specifically address the definition of legal pneumoconiosis. The BRB also vacated my finding that the evidence is insufficient to establish total disability due to pneumoconiosis and directed that I reconsider my findings in this regard as well, if on remand I find that Dr. Baker's opinion establishes legal pneumoconiosis.

The new regulatory provisions at 20 C.F.R. § 718.201 contain a modified definition of "pneumoconiosis" and codifies the case law as it has evolved relevant to finding the existence of pneumoconiosis. The regulations provide the following:

(a) For the purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis.

(1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(3) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (Dec. 20, 2000).

The aggravation of a pulmonary condition by dust exposure in coal mine employment must be significant and permanent in order to constitute "legal" pneumoconiosis as defined at 20 C.F.R. §718.201. Thus, medical opinions which diagnose only a temporary worsening of pulmonary symptoms upon exposure to coal dust, but no permanent effect, cannot support a finding of pneumoconiosis at 20 C.F.R. §718.202(a)(4). **Henley v. Cowan & Co., Inc.**, 21 BLR 1-147 (1999).

The Claimant was examined by board-certified Internal Medicine and Pulmonary Disease specialist, Dr. Baker, on March 13, 2000. (Dir. Ex. 12) A coal mine employment history of twelve years and a smoking history from 1967 to 1980 at the rate of one pack per day were recorded. On physical examination, Dr. Baker noted hearing inspiratory and expiratory wheezes bilaterally on auscultation. He read a chest x-ray as positive for pneumoconiosis with a 1/0 profusion. The pulmonary function study performed was indicative of a severe obstructive defect. An arterial blood gas test showed a mild resting arterial hypoxemia. Dr. Baker made a diagnosis of 1.) coal workers' pneumoconiosis based upon abnormal chest x-ray and significant duration of exposure; 2.) COPD with severe obstructive defect based upon the pulmonary function study; 3.) hypoxemia based upon the Claimant's PO2 value; 4.) chronic bronchitis based upon a history of cough, sputum production, and wheezing; and 5.) chest pain by history. Dr. Baker determined that the etiology of the Claimant's pneumoconiosis was coal dust exposure and that the etiology of his COPD, hypoxemia, and chronic bronchitis were coal dust exposure and cigarette smoking. The etiology of the Claimant's chest pain was noted to be ASHD. Dr. Baker opined that the Claimant suffers from a severe impairment with

decreased FEV1, chronic bronchitis, decreased PO2 and coal workers' pneumoconiosis. He found the Claimant to be totally disabled from performing his last coal mine employment.

The record also contains a May 23, 2000, letter from Dr. Baker to a Department of Labor claims examiner. (Dir. Ex. 16) In this letter Dr. Baker states that the Claimant has chronic obstructive airway disease with a severe obstructive impairment. The nature of the impairment is obstructive airway disease with associated chronic bronchitis and mild resting hypoxemia. This is due to both coal dust exposure and an approximately thirteen pack year smoking history. If the definition of pneumoconiosis provided by the claim's examiner is used, Dr. Baker stated, then the Claimant would be deemed to have pneumoconiosis as it is thought to play a causative role in his obstructive airway disease. The letter from the Department of Labor claims examiner is included in the record and the definition of pneumoconiosis stated in that letter is the one included in the regulations at §718.201. Dr. Baker also stated that he thinks the Claimant's impairment is related to both his cigarette smoking and to coal dust exposure.

In its remand order the BRB states that ". . . Dr. Baker . . . opined that claimant suffers from chronic obstructive pulmonary disease and chronic bronchitis, each of which he attributed to claimant's coal dust exposure." The Board then stated, "Thus, Dr. Baker diagnosed 'legal pneumoconiosis.'" (Slip op. p. 4, Emphasis added) It appears that this statement by the BRB amounts to a finding by it that the Claimant has, through Dr. Baker's report, established legal pneumoconiosis. Therefore, since the Board has so found, I will weigh Dr. Baker's opinion finding of "legal pneumoconiosis" against the opinions of other physicians of record who did not find the existence of the disease.

The record includes the deposition of Dr. Lane taken on April 30, 1994. (Er. Ex. 4) Dr. Lane's curriculum vitae is attached to the deposition transcript and reflects that he is board-certified in Internal Medicine. In the deposition, Dr. Lane testified that he examined the Claimant for purposes of diagnosing pneumoconiosis on December 7, 1993. A separate report of this examination is not included in the record. Dr. Lane stated that he recorded the Claimant's social, medical, and occupational histories, performed a physical examination, and ordered a chest x-ray, spirometry, EKG, and arterial blood gas testing. A twelve year coal mine employment history and a smoking history of a third of a pack per day for eleven years,

the Claimant having quit smoking fifteen years earlier, was recorded. On examination, Dr. Lane heard rhonchi. He interpreted the chest x-ray to be negative for pneumoconiosis. Dr. Lane stated that the arterial blood gas results were normal. Based upon the test results, histories and physical examination, Dr. Lane diagnosed COPD. He found no evidence of coal workers' pneumoconiosis or occupational lung disease. Dr. Lane opined that the Claimant's COPD was the result of cigarette smoking. In his deposition, he stated that before pneumoconiosis can be present in a symptomatic form, there should be x-ray evidence of it. Dr. Lane also stated that pneumoconiosis usually causes a restrictive lung defect.

The deposition of Dr. Lockey was taken on May 27, 1994. (Er. Ex. 3) No separate report of this examination is included in the record. Dr. Lockey testified that he is board-certified in Internal Medicine and Occupational Medicine. He stated that he examined the Claimant on April 12, 1994. He recorded the Claimant's social, occupational, and smoking histories, performed a physical examination and ordered a chest x-ray, spirometry, EKG, and arterial blood gas analysis. Dr. Lockey noted a smoking history of a third of a pack per day from the age of sixteen to twenty-eight. A coal mine employment history of eleven years was also recorded. On physical examination, Dr. Lockey noted wet rales and rhonchi on inspiration involving the left lower lung. He found the chest x-ray to be negative for pneumoconiosis. The arterial blood gas study produced normal results. Dr. Lockey found the pulmonary function study results to be consistent with mild airflow obstruction. The most probable etiology of this condition was the residual effects of the severe pneumonia the Claimant had suffered six years earlier. There was also a likelihood that the Claimant had a residual bronchiectasis involving his left lung field. None of these conditions were the result of occupational dust exposure. Dr. Lockey opined the Claimant should not return to work in a dusty environment because of his lung conditions. He placed no other work restrictions on the Claimant.

The deposition of Dr. Wright was taken on June 10, 1994. (Er. Ex. 1) Dr. Wright testified that he is a board-certified anesthesiologist. He examined the Claimant on May 28, 1994, and performed a complete pulmonary evaluation which included taking social, medical, and occupational histories, performing physical examination and reviewing a chest x-ray, spirometry results, EKG, and arterial blood gas analysis. No separate report of this examination is included in the record. Dr. Wright recorded twelve years of coal mine employment and a smoking history of 2

packs per day of eleven years, the Claimant having quit many years earlier. On physical examination, he noted that on auscultation bilateral expiratory wheezes and a few scattered rhonchi were heard. The rhonchi cleared with cough. The x-ray was found to be negative for pneumoconiosis by Dr. Wright. The spirometry was indicative of a severe obstructive impairment and a restrictive component could not be excluded. The arterial blood gas study was normal. Dr. Wright made a diagnosis of 1.) coal workers' pneumoconiosis, silicosis, siderosis or any other form of pneumoconiosis or any other occupational lung disease cannot be made; 2.) chronic bronchitis; 3.) probable old inflammatory process left lower lung; 4.) no clinical evidence of acute pneumonia; and 5.) chronic bronchitis with moderate to severe obstructive ventilatory impairment. Dr. Wright determined that the abnormal spirometry results were probably due to cigarette smoking. He also stated that before pneumoconiosis can be symptomatic, there must be x-ray evidence of it. If a chest x-ray is negative then pneumoconiosis is ruled out as being causative of a pulmonary abnormality.

Dr. Lockey again examined the Claimant on June 16, 2000. (Dir. Ex. 28) A twelve year coal mine employment history and a smoking history of a third of a pack per day from the age of sixteen to twenty-eight were recorded. On physical examination, Dr. Lockey noted inspiratory and expiratory wheezes and squeaks at the left lung base on auscultation with rhonchi. There were also scattered rhonchi noted at the right base. The chest x-ray, as read by Dr. Wiot, was negative for pneumoconiosis. The spirometry performed was indicative of a mixed obstructive and restrictive pattern with a significant response to bronchodilation. This severe airway obstruction was most likely causing air trappings which accounted for the Claimant's decreased FVC. The arterial blood gas and EKG were normal. Dr. Lockey found that there was no radiographic evidence of coal workers' pneumoconiosis. He diagnosed severe airway obstruction with air trappings with a significant broncho spastic component consistent with asthma. This asthma was unrelated to occupational dust exposure. Dr. Lockey also opined that the Claimant was totally disabled from his last coal mine employment.

The deposition testimony of Dr. Baker was taken on January 17, 2001. (Cl. Ex. 1) He reiterated the findings and opinions stated in his earlier reports. Dr. Baker also stated that even if the Claimant's chest x-ray was negative, he would still diagnose coal workers' pneumoconiosis. Pertinent to his final opinion was the length of the Claimant's exposure, his history

of bronchitis with cough, sputum production, wheezing, thirteen pack year smoking history, and ten year history of symptoms.

The record also contains a report authored by Dr. Branscomb, dated February 19, 2001. (Er. Ex. 13) Dr. Branscomb is board-certified in Internal Medicine. Based upon the medical evidence of record, as reviewed by him, Dr. Branscomb opined that the Claimant did not suffer from pneumoconiosis or any other occupationally acquired lung disease. He was totally disabled due to obstructive and restrictive disease. However, the etiology of this condition was recurrent pneumonia in a person with asthma.

Dr. Branscomb issued a supplemental medical report on February 20, 2001. (Er. Ex. 13) In this report he states he has reviewed the medical records of Dr. Chaney and the deposition of Dr. Baker. Neither report changed his previous opinion. He states that the recurrent pneumonia, wheezing attacks, and other symptoms described in his February 19, 2001 report, and the report of Dr. Baker, are not known to be associated with simple coal workers' pneumoconiosis. Therefore, he disagrees with Dr. Baker's finding of pneumoconiosis based on these symptoms.

The record contains a February 28, 2001, consultative report issued by board-certified Internal Medicine and Pulmonary Disease specialist, Dr. Fino. (Er. Ex. 9) Dr. Fino reviewed the medical evidence of record in issuing his opinion. He found the Claimant was totally disabled as a result of lung disease. However, he also found that neither coal dust exposure nor cigarette smoking had contributed significantly to the Claimant's severe obstructive defect. Dr. Fino opined the Claimant suffers from asthma based upon the pattern of lung function and significant bronchodilator response demonstrated on spirometry. There was not enough medical evidence to justify a finding of coal workers' pneumoconiosis.

The record contains a number of CT scan interpretations authored by Drs. Wiot and Wheeler. (Er. Ex. 2, 7, 10) These CT scans were performed on March 23, 1988, June 5, 1994, and June 16, 1998. Both physicians found no evidence of pneumoconiosis in any of the CT scans they reviewed. Dr. Wheeler noted observing a six millimeter nodule in the right lower lung compatible with a granuloma on the March 23, 1988, CT. Dr. Wiot, on review of this CT, opined there was a considerable infiltrate within the right upper lung. Dr. Wheeler found a small calcified granulomatoma in the left hillum and right lower lung compatible with an old tuberculosis after reviewing the

June 5, 1994, CT. He made nearly identical findings in his review of the June 16, 1998, CT.

Reviewing the medical narrative evidence of record I find that pneumoconiosis has not been established pursuant to Section 718.202(a)(4). In doing so I rely primarily on the medical opinions of Drs. Lockey, Branscomb, and Fino whose reports I find to be well-reasoned, well-documented and based upon the objective laboratory data of record. All three physicians considered the test result data and the Claimant's pertinent occupational, medical and social histories in reaching their conclusions. Furthermore, I find Dr. Lockey's opinion to be particularly probative given that he personally examined the Claimant on two occasions. Drs. Fino and Branscomb had the opportunity to review extensive medical data as well as the examination reports of other physicians of record. Drs. Lockey, Fino, and Branscomb are all highly qualified physicians each being board-certified Internal Medicine specialists. Given that their opinions are well-reasoned and supported and they have superior qualifications I find these three physicians entitled to great weight.

The CT scan readings of Drs. Wiot and Wheeler also support a finding that pneumoconiosis is not present. Both Drs. Wheeler and Wiot are board-certified radiologists who reviewed multiple CT scan results. As such, I find their opinions to be highly probative.

I assign less probative weight to the opinions of Drs. Lane and Wright. In his deposition, Dr. Lane stated that before pneumoconiosis can be present in a symptomatic form, there should be x-ray evidence of the disease. Dr. Wright also testified that before pneumoconiosis may be symptomatic there must be x-ray evidence of it. As the regulations permit a diagnosis of pneumoconiosis to be made by a physician exercising sound medical judgment, notwithstanding a negative x-ray, I find the overall opinions of Drs. Lane and Wright entitled to less weight.

While Dr. Baker is also a highly qualified specialist, he is the only physician of record to make a finding of pneumoconiosis. The initial problem with Dr. Baker's report is that it is equivocal. Although he attributes the pneumoconiosis he diagnosed in the Claimant to a synergistic combination of coal dust exposure and cigarette smoking he clearly states that he is unable to determine how much each of those factors contributed to the Claimant's breathing impairment. The

regulations require that in order to amount to legal pneumoconiosis the diagnosed chronic pulmonary disease or respiratory or pulmonary impairment must be significantly related to, or substantially aggravated by, dust exposure in coal mine employment. If Dr. Baker could not render an opinion on this issue far be it from me to try. A physician's opinion may be given little weight if it is equivocal or vague. Griffith v. Director, OWCP, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner probably had black lung disease); see also Justice v. Island Creek Coal Co., 11 B.L.R 1-91 (1988); Parsons v. Black Diamond Coal Co., 7 B.L.R 1-236 (1984).

The next problem that I find with Dr. Baker's report is that he did not consider the credible evidence in the record of the Claimant's history of recurring pneumonia and his history of asthma. I find this failure to do so significant to the point of rendering his diagnosis of little value. Drs. Fino, Lockey, Branscomb, Wright, and Lane all opined that the Claimant's pulmonary condition is the result of some factor other than occupational dust exposure. Drs. Wheeler and Wiot both found the CT scans they reviewed to be negative for pneumoconiosis. Accordingly, I find that based upon the clear preponderance of contrary narrative medical evidence outweighs Dr. Baker's sole finding of legal pneumoconiosis.

Total Disability Due to Pneumoconiosis:

The Board did not disturb my finding that the Claimant was totally disabled due to a respiratory or pulmonary condition. However, the Board vacated my finding that the Claimant's total disability was due to pneumoconiosis based on its finding that Dr. Baker's report demonstrated the existence of legal pneumoconiosis. Because I have found that Dr. Baker's report is outweighed by other credible evidence of record, it cannot be established that his respiratory disability is due to pneumoconiosis. Every physician of record who offered an opinion as to total disability causation, other than Dr. Baker, found that the Claimant's pulmonary impairment was due to something other than coal dust exposure. The opinions of Drs. Lockey, Fino and Branscomb, unlike that of Dr. Baker, are well-reasoned and well-documented on this issue. Accordingly, I find that the preponderance of the medical narrative evidence fails to support a finding of total disability due to pneumoconiosis.

Entitlement:

Unfortunately, as the Claimant has failed to establish the existence of pneumoconiosis or total disability arising therefrom, I find that he is not entitled to benefits under the Act.

ORDER

It is therefore ORDERED that the claim of ROY JOHNSON, JR., for benefits under the Act continues to remain **DENIED**.

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DANIEL J. ROKETENETZ
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.